| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345183 | A. BUILDING _____ B. WING _____ | C 12/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL HEALTH CARE & REHAB | 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investiation survey were conducted on 12/5/2022 through 12/8/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LJCH11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey were conducted from 12/5/2022 through 12/8/2022. Event ID# LJCH11<br><br>Intakes investigated:<br>NC00185987<br>NC00192054<br>NC00188189<br>NC00187307<br>NC00186999<br>NC00185798<br>NC00186715<br><br>23 of the 23 complaint allegations were not substantiated. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interview and staff interviews, the facility failed to accurately include information on the Minimum Data Set (MDS) assessment in the area of dialysis and antipsychotic medication review for 2 of 19 residents reviewed (Resident #32 and Resident #20). | F 641 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Minimum Data Set (MDS) Nurse completed a review of the medical record | 12/29/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/29/2022

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| F 641 | Continued From page 1<br>Findings included:<br><br>1. Resident #32 had been admitted on 9/22/22 and readmitted on 11/15/22. Her diagnoses included end stage renal disease and diabetes.<br><br>a. A hospital discharge summary dated 9/22/22 noted Resident #32 had diagnoses including End-Stage Renal Disease requiring hemodialysis which she received every Monday, Wednesday, and Friday.<br><br>Nursing documentation dated 9/23/22 at 6:23 PM noted Resident #32 had received dialysis this day.<br><br>Resident #32's Admission MDS assessment dated 9/29/22 included a diagnosis of End-Stage Renal Disease. The assessment did not indicate she received dialysis.<br><br>b. Nursing documentation dated 11/16/22 at 10:49 AM noted Resident #32 was out of the facility to dialysis this day.<br><br>A Nurse Practitioner note dated 11/19/22 indicated she had a diagnosis of End Stage Renal Disease requiring hemodialysis.<br><br>Resident #32's most recent quarterly MDS assessment dated 11/22/22 included a diagnosis of End-Stage Renal Disease. The assessment did not indicate she received dialysis.<br><br>An interview with Resident #32 was conducted on 12/6/22 at 9:41 AM. She stated she received dialysis three times a week, every Monday, Wednesday, and Friday. | F 641 | for resident #32 on 12/13/22, and completed a modification of Section O, to reflect receiving dialysis and correct MDS was transmitted on 12/16.<br><br>MDS nurse completed a review of the medical record for resident #20 on 12/23/22, completed modification of Section N, to reflect antipsychotic review and corrected MDS was transmitted on 12/27/22.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>Regional MDS Nurse and facility Director of Nursing completed and review of current residents receiving antipsychotic medication, to ensure that their current MDS was coded correctly to reflect antipsychotic review, this was completed on 12/20/22.<br>The audit results did not reflect any other discrepancies in coding related to anti<br><br>Resident #32 is the only resident with a diagnosis End-Stage Renal Disease and receiving dialysis as of 12/27/22.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>As of 12/20/2022, Regional MDS Nurse re-educated facility MDS Nurse on proper | |

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| F 641 | Continued From page 2<br>An interview with MDS Nurse #1 was conducted on 12/8/22 at 11:00 AM. After reviewing Resident #32's MDS assessment, she stated dialysis should have been indicated, and this had been missed.<br><br>An interview with the Director of Nursing (DON) was conducted on 12/8/22 at 12:10 AM. She stated the MDS assessment should accurately reflect the resident's condition.<br><br>2. Resident #20 had been readmitted on 9/2/22. Her diagnoses included anxiety and depression.<br><br>A psychiatry progress note dated 11/17/22 recorded Resident #20 had been receiving aripiprazole (an atypical antipsychotic medication given for major depressive disorders) and had diagnoses including depression, anxiety, insomnia, and Post-Traumatic Stress Disorder.<br><br>The November 2022 Medication Administration Record (MAR) was reviewed and revealed Resident #20 had received aripiprazole 10 milligrams (mg) daily for depression.<br><br>The Annual Minimum Data Set (MDS) assessment dated 11/23/22 indicated Resident #20 had diagnoses including anxiety and depression. The Medications Received section noted antipsychotic medication had been received 7 out of 7 days of the assessment period. The Antipsychotic Medication Review section noted no antipsychotic medications had been received.<br><br>An interview with MDS Nurse #1 was conducted on 12/8/22 at 11:00 AM. After reviewing Resident #20's MDS assessment, she stated antipsychotic | F 641 | coding of MDS, per RAI Manual, Section N, related to coding of antipsychotic medication reviews and Section O, receiving dialysis services.<br><br>Regional MDS Nurse will review 5 random, resident assessments, weekly for 4 weeks, then 5 resident assessments bi-weekly for 3 months, coding of Antipsychotic reviews and resident receiving Dialysis services are coded accurately<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>4. MDS Nurse/DON/Regional MDS/Unit Manager will report findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for six months.<br><br>5. Compliance Date:<br>12/29/22 | |

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| F 641 | Continued From page 3<br>medication use should have been indicated and this had been missed.<br><br>An interview with the Director of Nursing (DON) was conducted on 12/8/22 at 12:10 AM. She stated the MDS assessment should accurately reflect the resident's condition. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)- | F 656 | | 12/29/22 |

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| F 656 | Continued From page 4<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, resident and staff interviews, the facility failed to develop and implement a care plan that addressed discharge plans for 1 of 1 resident reviewed for discharge (Resident #3).<br><br>Findings included:<br><br>Resident #3 was admitted to the facility 8/12/2021 with diagnoses to include lung disease, diabetes, and hypertension. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/1/2022 assessed Resident #1 to be cognitively intact. The MDS documented that Resident #3 did not have an active plan in place to return to the community.<br><br>A review of the care plans last reviewed 11/1/2022 revealed there were no care plans in place that addressed long-term care. No care plan was in place that addressed a discharge | F 656 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>As of 12/27/22, facility Social Worker update the area plan for resident #3, to include current discharge plans.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>As of 12/22/22 all resident care plans have been reviewed by Social Worker and Regional Minimum Data Nurse (MDS) to ensure that every current resident has a discharge status care plan in place. As of 12/29/22Social Worker updated all care plans to show discharge status.<br><br>3. Address what measures will be put | |

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| F 656 | Continued From page 5<br>plan for Resident #3.<br><br>A social work note dated 10/25/2022 documented that Resident #3 wanted to go to Assisted Living Facility (ALF). The note documented that the Social Worker (SW) was going to start working on a discharge and determine an appropriate level of care for Resident #3.<br><br>A social work note dated 11/16/2022 documented that Resident #3 "hopes to go to ALF in the future".<br><br>Resident #3 was interviewed on 12/6/2022 at 9:00 AM. Resident #3 reported she had been trying to make plans to discharge from the facility to live independently and she was waiting for to hear if she had an apartment available. Resident #3 reported that for a while she was going to live with her brother, then that changed, and she was going to stay at the facility for long-term care, then she decided she was ready to move out on her own. Resident #3 reported the facility was helping her to find an apartment or assisted living facility.<br><br>The SW was interviewed on 12/8/2022 at 12:01 PM. The SW reported that her last day to work was 12/6/2022. The SW reported that the facility was waiting for Resident #3 to be accepted by an ALF for admission. The SW reported that when Resident #3 was admitted to the facility, a care plan should have been developed that addressed her discharge plan. The SW reported Resident #3 was one of the first residents she admitted and was not aware that a care plan was needed that addressed discharge or long-term care plans and she did not initiate a care plan. | F 656 | into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Regional MDS Nurse re-educated Social Worker, MDS Nurse, and Activities Director on Care Plan process for discharge planning and care planning for discharge plans.<br><br>MDS Nurse/Director of Nursing/Regional MDS Nurse designee will monitor 5 resident care plans weekly x□s 4 weeks, 5 care plans 3 times per week for 4 weeks, then 5 care plans weekly for 4 weeks to ensure all residents have care plan for discharge plans.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>MDS Nurse will report findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review Monthly and make any necessary recommendations immediately for six months.<br><br>5. Compliance Date:<br>12/29/22 | |

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| F 656 | Continued From page 6<br>The administrator was interviewed on 12/8/2022 at 2:03 PM. The Administrator reported a care plan that addressed resident plans for discharge or staying in the facility for long-term care should be developed upon admission to the facility and adjusted as the resident plans changed. | F 656 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, resident and staff interviews, the facility failed to apply compression hose prescribed to control lower leg swelling to 1 of 1 resident reviewed for quality of care (Resident #12).<br><br>Findings included:<br><br>Resident #12 was admitted to the facility on 9/29/2022 with diagnoses to include fluid overload, cellulitis (skin infection) of lower leg, and hypertension. The admission Minimum Data Set (MDS) assessment dated 10/6/2022 assessed Resident #12 to be cognitively intact without behaviors or refusal of care. The MDS documented Resident #12 required extensive assistance of one person to dress. | F 684 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>As of 12/09/22, resident # 12 has been wearing, compression stockings, as ordered by the physician.<br><br>As of 12/9/2022 Director of Nurse re-educated nurse #1 on Ted Hose application and documentation<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>As of 12/22/22 the Director of Nursing | 12/29/22 |

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| F 684 | Continued From page 7<br>A physician order dated 10/18/2022 ordered for compression hose to be applied to Resident #12's lower legs every morning at 8:00 AM. The order further specified for the compression hose to be removed at 8:00 PM.<br><br>A care plan initiated 10/18/2022 addressed edema (swelling) of the lower legs and directed compression hose to be applied to lower legs on in the morning and off in the evening.<br><br>A nurse practitioner note dated 11/28/2022 documented that the compression hose were used to control lower leg swelling for Resident #12. The note documented that the compression hose were keeping the lower leg swelling under control and for nursing staff to continue the use.<br><br>Resident #12 was observed on 12/5/2022 at 11:42 AM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs. Resident #12 reported she was waiting for staff to apply the compression hose and she was concerned because her lower legs were very swollen.<br><br>Resident #12 was observed again on 12/5/2022 at 2:42 PM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs. Resident #12 reported no staff had applied the compression hose and she was unable to apply them without help.<br><br>Resident #12 was observed on 12/6/2022 at 9:58 AM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs.<br><br>Nurse #1 was interviewed on 12/6/2022 at 2:49 | F 684 | (DON) audited all current resident orders for the use of Ted Hose. During audit on 12/22/2022 DON observed all residents with orders for Ted Hose to ensure they were in place. As a result of audit no other residents were affected.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>As of 12/23/22, the Director of Nursing has re-educated all Nurses, Certified Nursing Assistants (CNA), and Medication Aides on the use of and documentation of applying Ted Hose as ordered. Any nurses, CNAs, and Medication Aides who did not attend this education as of 12/23/22, Will not be allowed to work until they received education. The facility DON or administrative nurse will monitor to ensure current staff receive education, related to observation and documentation for residents with orders with compression stockings.<br><br>DON or administrative nurses will complete observation audits and cross reference resident medical records, 5 residents daily for 5 days, for 4 weeks, then 5 residents monthly for 3 months.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>DON will complete a summary of the audit results, to the Quality Assurance Performance Improvement (QAPI) | |

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| F 684 | Continued From page 8<br>PM. Nurse #1 reported she was assigned to Resident #12, and she had checked the MAR to indicate the compression hose had been applied to Resident #12. When Nurse #1 observed Resident #12 at 2:49 PM she reported that she had thought the nursing assistant (NA) had applied the compression hose, but she had not checked.<br><br>NA #1 was interviewed on 12/6/2022 at 2:54 PM. NA #1 reported she was assigned to provide care to Resident #12, and she was not aware Resident #12 required compression hose to be applied.<br>NA #2 was interviewed on 12/8/2022 at 10:49 AM. NA #2 reported she had provided a shower to Resident #12 on 12/5/2022 and had taken to her to therapy and reported she thought that the therapist had applied the compression hose. NA#2 reported she had not checked on Resident #12 after the shower to see if the compression hose were applied.<br><br>The Director of nursing (DON) was interviewed on 12/8/2022 at 1:28 PM. The DON reported that she expected the staff to communicate when tasks had been completed, and she expected the nursing staff to check behind the NA staff when compression hose needed to be applied. | F 684 | committee for any needed improvement. QAPI committee will review monthly, to ensure continued compliance.<br><br>5. Compliance Date: 12/29/22 | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly | F 812 | | 12/29/22 |

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| F 812 | Continued From page 9<br>from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and review of records, the facility failed to 1) wash dishes in the dish machine in water that reached at least 155 degrees Fahrenheit (F), per manufacturer recommendations, 2) store frozen foods at least 0 degrees F, and 3) store canned goods and snacks off the floor. This failure had the potential to effect 87 of 88 residents.<br><br>The findings included:<br><br>1. A continuous observation of the dish machine (DM) in use occurred on 12/07/22 at 9:50 AM until and 10:30 AM. The Assistant Dietary Manager (ADM) was observed washing meal trays, small bowls, and insulated dome lids. Each item was stored ready for use. The wash cycle temperature gauge consistently remained at 128 degrees F. The ADM stated when she observed the wash cycle temperature gauge earlier that morning (12/7/22), the wash cycle reading was 158 degrees F. The ADM stated she would notify her supervisor.<br><br>Manufacturer instructions for the wash cycle | F 812 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>As of 12/7/22, the dish machine (DM) gauge was replaced by the Maintenance Director and water heater temperature adjusted to manufacture recommendations of 155-165 degrees Fahrenheit.<br>As of 12/7/2022, freezer temperature is reading at or below 0 degrees following service from outside company.<br><br>The Dietary Manager re arranged the kitchen storage area to ensure that all canned goods, snacks were removed from the floor. This was completed on 12/10/2022<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: | |

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| F 812 | Continued From page 10<br>recorded on the DM were, Wash Cycle 155 - 165 degrees Fahrenheit.<br><br>An interview with the Certified Dietary Manager (CDM) on 12/07/22 at 10:00 AM revealed he notified the Maintenance Director the prior week that the wash cycle gauge was not working, the Maintenance Director had to order a new gauge and he planned to replace the gauge that day (12/7/22) after staff finished washing dishes. He stated that until the gauge was replaced, he advised his staff to monitor the wash cycle temperature gauge when the dish machine was being used.<br><br>The Maintenance Director was observed to replace the wash cycle temperature gauge from 10:30 AM until 11:15 AM. The wash cycle temperature reading was 145 degrees once the gauge was replaced. The Maintenance Director stated on 12/7/22 at 11:33 AM that the water would continue to heat up and he would come back to check the temperature. He stated that he was notified on Monday, 12/5/22 that the wash cycle gauge was not working so he ordered a new gauge and just replaced it.<br><br>The DM was observed in use on 12/07/22 at 11:49 AM by Dietary Aide (DA) #1. DA #1 washed clear plastic cups, insulated cups, and a coffee pot. These items were stored ready for use. The wash cycle temperate reading was 150 degrees. DA #1 stated that the water for the wash cycle was hot enough and that the DM was working.<br><br>During a follow up interview on 12/08/22 at 9:19 AM with the CDM and ADM, the CDM stated he had not reviewed the DM temperature logs to see if there were problems, but he expected staff to | F 812 | No specific resident was named, although any resident had the potential to be affected by the alleged deficient practice.<br><br>As of 12/23/22, the Maintenance Director has checked all freezer units for correct temperature setting.<br>As of 12/7/2022 the Dish Machine had been checked by the Maintenance Director for correct temperature range.<br>Outside vendor checked dish machine for proper functioning as of 12/20/22.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>All dietary staff have been re-educated by the Dietary Director on reporting any equipment issues immediately to their supervisor for repair.<br>As of 12/23/22 Dietary manager has re-educated dietary staff on proper food storage, including not storing items on the floor.<br>Admin/designee will monitor dish machine and freezer logs daily, 5 days/week, for 4 weeks, then weekly for 4 weeks, to ensure all temperatures are recorded and at manufacturer recommendations.<br>Administrator/Designee will monitor supply room's daily for 4 weeks, then weekly for 4 weeks, to ensure all food items are stored and dated properly.<br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Administrator will complete a summary of | |

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| F 812 | Continued From page 11<br>notify him of any temperatures out of range and he would notify the Maintenance Director. The ADM stated that any time DM temperatures were found to be less than what they should be, the Maintenance Director was notified, followed up and and made repairs as needed.<br><br>The Administrator was interviewed on 12/08/22 at 12:09 PM. He stated he expected staff to report equipment concerns to their supervisor and the supervisor to report to maintenance for follow up.<br><br>2. An observation of the walk-in freezer occurred on 12/5/22 at 11:10 AM. The thermometer reading was 20 degrees F. A follow up observation of the walk-in freezer occurred on 12/7/22 at 9:55 AM and 10:45 AM. The thermometer reading was 10 degrees F with each observation. The following items were stored: waffles, broccoli, mixed vegetables, ice cream, chicken breast, zucchini, popcorn shrimp, BBQ pork, chopped, beef patties, vegetable spring rolls, and breaded flounder.<br><br>On 12/7/22 at 10:00 AM and 10:50 AM, ice cream temperatures were observed at 9 degrees F.<br><br>Review of temperature logs revealed the following freezer temperatures that exceeded 0 degrees F:<br>September 2022 - 22 days; temperature range of 9 degrees F - 27 degrees F<br>October 2022 - 8 days; temperature range of 4 degrees F - 10 degrees F<br>November 2022 - 28 days; temperature range of 7 degrees F - 21 degrees F<br>December 2022 - 2 days; temperature range of 4 degrees F - 10 degrees F | F 812 | the audit results and present monthly to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly, to ensure continued compliance.<br><br>5. Compliance Date: 12/29/22 | |

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The Assistant Dietary Manager (ADM) stated in an interview on 12/07/22 at 11:05 AM that on the dates in September 2022 and November 2022 she recorded freezer temperatures above 0 degrees F, she reported this to her supervisor, but she did not know why the freezer temperatures remained above 0 degrees F after the temperatures were reported. She stated that she did not record temperatures above 0 degrees in October 2022 and she did not know if the temperatures recorded above 0 degrees In October 2022 were reported to the Maintenance Director because that employee was no longer employed.

The CDM stated in an interview on 12/07/22 at 11:10 AM that he started in this role in September 2022, but he was not aware that there was a problem with the freezer. He stated that on the dates he recorded freezer temperatures above 0 degrees F, he reported this to the Maintenance Director. He stated the Maintenance Director checked the freezer and determined that the temperature dial needed to be adjusted, but he did not know why the freezer temperatures remained above 0 degrees F after the Maintenance Director was notified. The CDM stated he observed the freezer temperature at 10 degrees F that morning (12/7/22) at 5:00 AM but had not reported it to the Maintenance Director yet, because he was not in the facility at that time. The CDM also stated that he had not reviewed the temperature logs to identify freezer temperatures above 0 degrees F.

The Maintenance Director stated in an interview on 12/7/22 at 2:49 PM that he was made aware around lunch time that day (12/7/22) that the freezer temperature was not cold enough. He

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stated he called a contractor to check the freezer and found that the temperature dial was set at 0 degrees F and so the contractor turned the temperature dial down to -10 degrees in order to maintain the freezer at 0 degrees F or below. He stated the current temperature of the freezer was 0 degrees F. The Maintenance Director stated this also occurred in September 2022, the temperature dial was set too high and when the contractor came to check the freezer, he adjusted the temperature. He stated he had not been notified since September 2022 that the freezer temperature was above 0 degrees F.

The Administrator was interviewed on 12/08/22 at 12:09 PM. He stated that expected staff to monitor freezer temperatures and report any temperatures out of range to their supervisor, and the supervisor to notify Maintenance Director for follow up.

3. An observation of the dry storage room occurred with Certified Dietary Manager (CDM) on 12/05/22 at 11:00 AM. The following items were observed stored on the floor:
1 case of animal crackers
2 cases of canned kidney beans
1 case of canned pizza sauce
1 case of canned apple sauce
1 case of canned pinto beans
1 case of canned apples
1 case of canned baked beans
1 case of canned tomato juice
1 case of canned fruit cocktail

The CDM stated in an interview on 12/5/22 at 11:05 AM that the items stored on the floor were received on Friday, 12/2/22 and at the time he received the items, the storage racks for canned

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| F 812 | Continued From page 14<br>goods were full and there was no room on the storage racks to store these additional items.<br><br>The Administrator was interviewed on 12/08/22 at 12:09 PM. He stated expected all food items to be stored per facility policy. | F 812 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance | F 842 | | 12/29/22 |

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| F 842 | Continued From page 15<br>with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and staff interviews, the facility failed to accurately document the application of the compression | F 842 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient | |

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| F 842 | Continued From page 16<br>hose on the medication administration record (MAR) for 1 of 19 residents reviewed for record accuracy (Resident #12.)<br><br>Findings included:<br><br>Resident #12 was admitted to the facility on 9/29/2022 with diagnoses to include fluid overload, cellulitis (skin infection) of lower leg, and hypertension.<br><br>A physician order dated 10/18/2022 ordered for compression hose to be applied to Resident #12's lower legs every morning at 8:00 AM. The order further specified for the compression hose to be removed at 8:00 PM.<br><br>The medication administration record (MAR) for December 2022 was reviewed. The order for compression hose to be applied on 12/5/2022 and 12/6/2022 was marked as completed by evidence of the nurse initials and a check mark.<br><br>Resident #12 was observed on 12/5/2022 at 11:42 AM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs. Resident #12 reported she was waiting for staff to apply the compression hose and she was concerned because her lower legs were very swollen. Resident #12 was interviewed on 12/5/2022 at 11:42 AM and she reported that she was waiting for staff to apply the compression hose for her. She did not have compression hose on her lower legs.<br><br>Resident #12 was observed again on 12/5/2022 at 2:42 PM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs. Resident #12 reported no staff | F 842 | practice:<br><br>As of 12/23/22, resident # 12□s medical record has been corrected to show compression stockings, was not applied as ordered. As of 12/9/2022 Director of Nursing re-educated nurse # 1 on proper documentation process for Medication Administration Record (MAR).<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Director of Nursing (DON) and nurse Managers audited all records for use of Ted Hose to ensure proper documentation on resident MAR□s. As a result of audit there were no other affected residents.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>As of 12/23/22 Director of Nursing/Nurse Managers re-educated all Nurses, Medication Aides, Certified Nursing Assistance on proper documentation and application of Ted Hose use. Director of Nursing/designee will monitor 5 resident□s weekly x□s 4 weeks, 5 resident□s 3 times per week for 4 weeks, then 5 resident□s weekly for 4 weeks to ensure all sections are complete and accurate to include application of TED Hose.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: | |

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| F 842 | Continued From page 17<br>had applied the compression hose and she was unable to apply them without help.<br><br>Resident #12 was observed on 12/6/2022 at 9:58 AM. Resident #12's lower legs were swollen, and she did not have compression hose on her lower legs.<br><br>Resident #12 was interviewed on 12/6/2022 at 9:58 AM. Resident #12 reported she was unable to apply her compression hose and she was waiting for the nurse or the nursing assistant to come and apply the compression hose. Resident #12 reported that she was concerned her legs were swelling without the hose.<br><br>Nurse #1 was interviewed on 12/6/2022 at 2:49 PM. Nurse #1 reported she was assigned to Resident #12, and she had checked the MAR to indicate the compression hose had been applied to Resident #12. When Nurse #1 observed Resident #12 at 2:49 PM she reported that she had thought the nursing assistant (NA) had applied the compression hose, but she had not checked. Nurse #1 reported she should have checked to make sure the compression hose was applied to Resident #12 before documenting it had been completed.<br><br>NA #1 was interviewed on 12/6/2022 at 2:54 PM. NA #1 reported she was assigned to provide care to Resident #12, and she was not aware Resident #12 required compression hose to be applied.<br><br>NA #2 was interviewed on 12/8/2022 at 10:49 AM. NA #2 reported she had provided a shower to Resident #12 on 12/5/2022 and had taken to her to therapy and reported she thought that the therapist had applied the compression hose. | F 842 | DON will report its findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for 6 months.<br><br>5. Compliance Date: 12/29/2022. | |

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| F 842 | Continued From page 18<br>NA#2 reported she had not checked on Resident #12 after the shower to see if the compression hose were applied.<br><br>The Director of nursing (DON) was interviewed on 12/8/2022 at 1:28 PM. The DON reported that she expected the staff to communicate when tasks had been completed, and she expected the nursing staff to check behind the NA staff when compression hose needed to be applied before documenting the task had been completed. | F 842 | | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. | F 867 | | 12/29/22 |

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| F 867 | Continued From page 19<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities. | F 867 | | |

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| F 867 | Continued From page 20<br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: | F 867 | | |

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| F 867 | Continued From page 21<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions the committee put into place in May 2019. This was for 2 re-cited deficiencies which were originally cited on 5/23/2019 (F656 and F812), and 7/15/2021 (F812) during the recertification/complaint survey, and on the current recertification/complaint survey on 12/8/2022 (F656 and F812). The continued failure of the facility during the two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>1. F656<br>During the recertification survey of 5/23/2019, the facility failed to develop a comprehensive person-centered plan to address discharge plans for 1 of 1 residents reviewed (Resident # 146).<br><br>The Administrator was interviewed on 12/8/2022 at 2:03 PM. The Administrator reported the facility had weekly QAPI meetings that included all | F 867 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>No resident named.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>No residents were affected but all residents have the potential to be affected.<br><br>The Regional Director of Operations (RDO) and the Regional Clinical Nurse (RCN) educated the facility Quality Assurance Performance Improvement (QAPI)Committee which includes the Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), minimum data set (MDS)nurse, Social Worker, Business Office Manager, Dietary Manager, Maintenance Supervisor, and Housekeeping Manager ,this education included how to begin identifying other issues quality issues (QI) utilizing the QAPI process. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345183 | A. BUILDING _____ B. WING _____ | C 12/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| UNIVERSAL HEALTH CARE & REHAB | 430 BROOKWOOD AVENUE NE CONCORD, NC 28025 |

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| F 867 | Continued From page 22<br>department managers, the physician and a quarterly QAPI meeting that included the pharmacist, as well as the physician and department managers. The Administrator reported he wanted to continue the audit process for a full year after deficient practice was identified to prevent future issues.<br><br>2. F812:<br><br>During the recertification survey of 5/23/2019, the facility failed to allow dishware to air dry; ensure foods were covered, labeled, and dated when stored, maintain the hood vents, walk-in refrigerator fans and ceiling and dish room floor in a clean sanitary manner and propped open the back door, which allowed flies to enter the kitchen. The facility additionally failed to ensure temperatures for the dish machine were documented at the required temperatures. This was evident in 2 of 2 kitchen observations.<br><br>During the recertification survey of 7/15/2021 the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer and failed to label items in the dry storage room, walk-in refrigerator, and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. These practices had the potential to affect food served to residents.<br><br>During the recertification survey of 12/8/2022 the facility failed to 1) wash dishes in the dish machine in water that reached at least 155 degrees Fahrenheit (F), per manufacturer recommendations, 2) store frozen foods at least 0 degrees F, and 3) store canned goods and snacks off the floor. This failure had the potential to effect 87 of 88 residents. | F 867 | Examples utilized during this training were reviewing F8679 the following: facility rounding tools, workorders, electronic health record (AHT), resident council minutes, grievance logs/, audits related to the plan of correction, pharmacy recommendations, registered dietician recommendations and regional facility consultant recommendations. This education occurred on 12/23/2022.<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiencies cited remains corrected and/or remain in compliance with the regulatory requirements. The Executive QAPI committee will continue to meet at a minimum of quarterly and QAPI committee monthly with oversite by a corporate staff member. The committee will meet at a minimum of quarterly to review any issues of quality assessment and assurance activities. Issues identified by the committee will be addressed by development and implementation of additional plans as needed for the facility.<br>As of 12/29/2022 facility Administrator will review all current plan of corrections monthly to ensure all corrective actions are followed and effective on going. | |

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| F 867 | Continued From page 23<br><br>The Administrator was interviewed on 12/8/2022 at 2:03 PM. The Administrator reported the facility had weekly QAPI meetings that included all department managers, the physician and a quarterly QAPI meeting that included the pharmacist, as well as the physician and department managers. The Administrator revealed the kitchen audits had not continued for the kitchen and a change in kitchen management also contributed to the re-cite of F812. The Administrator reported he wanted to continue the audit process for a full year after deficient practice was identified to prevent future issues. | F 867 | 3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Administrator will report findings to the QAPI committee monthly. The QAPI committee minutes will be reviewed by a RDO and/or RNC at a minimum of monthly for three months and quarterly for 2 quarters to ensure the facility has identified and addressed quality deficiencies appropriately.<br><br>4. Compliance Date: 12/29/22 | |